

## **SUMMARY: FILE REVIEW**

### **Of the Death of a Child Known to the Director in 2019**

#### Circumstances of the Fatality

The review examined the case files of a child who died from an undetermined cause. The director was providing services to the child and their family at the time of the death in relation to abuse and neglect.

#### Findings

Four months before the child's death, the director initiated a child protection response to assess concerns for the child's siblings in relation to two specific issues present in this family. The director's assessment of those concerns was only partially completed and collateral checks with the community service practitioners, who could best speak to these concerns, did not occur. The child protection response concluded shortly after the child was born. Prior to completing this response, the director did not contact the child's mother to inquire about how she was coping, or to discuss safe sleeping practices. Additionally, the director overrode the rating of an assessment tool to reflect a lower risk rating and provided an inaccurate rationale for the override. Two weeks later, the child was found deceased.

#### Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan for the involved staff to receive training regarding the *Child Protection Response Policies* and the guidelines for intimate partner violence and problematic substance use.

**The review was completed in February 2020. The above action plan was fully implemented in February 2020.**